STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155193	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	377 WESTRIDGE BOULEVARD GREENWOOD, IN46142

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 15, 16, 17, 18, and 19, 2011 Facility number: 000101 Provider number: 155193 AIM number: 100291290 Survey team: Karina Gates, BHS TC Marcy Smith, RN Leia Alley, RN (8/15, 8/16, 8/17, and 8/18/11) Courtney Mujic, RN Barb Hughes, RN Census bed type: SNF/NF: 159 Total: 159 Census payor type: Medicare: 44 Medicaid: 102 Other: 13 Total: 159 Sample: 24 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000	Thank you for visiting the facility and conducting the survey. Please consider a desk review of the citations. If you have any questions, feel free to contact the facility. Brenda Meridith, RN Surveyor Supervisor Long Term Care Division Indiana State Department of Health Dear Brenda: Facility #: 000101 Provider #: 155193 Survey Event ID: C39N11 Survey Date: August 19, 2011 Please accept the addendum to clarify the plan of correction responses. F282 The care plan for the facility has been worded differently to exactly describe the care delivered to the dialysis	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 8/24/11 by Jennie Bartelt, RN.		residents. This step is complete. Compliance is complete. Each month, the MDS Coordinators or designee will audit each dialysis resident to ensure the care plan is worded correctly to reflect the care being delivered. This will be completed consistently for a period of three months. If substantial compliance has been established, the audit will not be continued monthly. The audit will be completed annually, thereafter to ensure compliance is maintained. The expected compliance rate is 100%. If the compliance rate is below 100%, the audits will continue until 100% is maintained for three consecutive months. The dietitian completed an audit of the residents in the facility to match the MD order to the dietary computer to the actual tray card. This will be completed once per month for three months, per the dietitian, and turned into the Performance Improvement Committee for review. The expected compliance rate is	

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			100%. If the compliance rate is below 100%, the audits will continue until 100% is maintained for three consecutive months. Once the three months is complete and compliance is established, the audit will fall into the annual rotation to maintain compliance. F323 Facility rounds will be monitored and evaluated by the Performance Improvement Committee. The rounds will be completed weekly to make sure there are no chemicals on the dementia unit. The expected compliance rate is 100%. The rounds will be turned into and reviewed by the Performance Improvement Committee monthly for three months. The audits will be continued if 100% is not met until for a period of three consecutive months. Following three consecutive months of compliance, the audits will be conducted annually.	

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			F371 Meal service will be monitored by the dietitian, or designee, weekly to ensure proper handling of the food. 1. Temp logs will be reviewed by the dietitian and then passed along to the Performance Improvement Committee. The expected compliance rate is 100%. The rounds will be turned into and reviewed by the Performance Improvement Committee monthly for three months. The audits will be continued if 100% is not met until for a period of three consecutive months. Following three consecutive months of compliance, the audits will be conducted annually. 2. The meal service audits will be completed weekly by the dietitian, or designee. The expected compliance rate is 100%. The audits will be turned into and reviewed by the Performance Improvement Committee monthly for three months. The audits will be continued if 100% is not met until for a period of three consecutive months.	

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			Following three consecutive months of compliance, the audits will be conducted annually.	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure a dialysis care plan was followed for 1 of 1 resident reviewed for dialysis care. (Resident #133) The facility also failed to ensure the resident's diet was served as ordered by the physician for 1 of 14 residents reviewed related to dietary care needs. (Resident #74) The deficient practice affected 2 of 24 sampled residents reviewed related to following physician's orders and the plan of care. Findings include: 1. The record of Resident #133 was reviewed on 8/16/11 at 11:30 a.m. Diagnoses for Resident #133 included, but were not limited to, end stage renal disease and encephalopathy. A recapitulated physician's order for July 2011, with an original date of 11/1/2010, indicated Resident #133 received dialysis	F0282	It is the intention of Kindred Transitional Care and Rehabilitation Center-Greenwood to provide services and care in accordance with the resident plan of care. What corrective actions will be taken for those residents found to be affected by the decicient practice. 1. Resident #133 care plan was updated to reflect the care provided. 2. The diet for resident #74 was immediately corrected. How other residents having the same deficient practicewill be identified and what corrective action will be taken.1. All resident who recieve dialysis have had their plan of care reviewed and updated to reflect the care provided. .2. The diets for each resident were pulled from the Doctors orders and matched up with the information in the dietary computer whichs creates the diet served from the kitchen to ensure accuracy. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice doed not recur.1. The care plans have	09/15/2011

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	treatments 3 times per week at an outside facility. A care plan for Resident #133, dated 5/5/11 and current through 10/1/11, indicated the resident had a shunt (an access site for the dialysis treatments) in her left upper arm. The careplan indicated a problem of "Potential for complications related to hemodialysis...." A goal was "Resident will not develop complications related to hemodialysis...." Approaches included, "Check shunt site for patency, palpate for thrill [a vibration], auscultate for bruit [a sound] every shift. Notify physician of absence of thrill or bruit...Check shunt site for s/s [signs/symptoms] of infection, pain or bleeding daily...." A Dialysis Log for July 2011, for Resident #133 indicated her shunt site had been checked on July 2, 5, 7, 9, 12, 16, 23, 26, 28 and 30, 2011, after she returned from her dialysis treatments. There was no documentation in her record to indicate her shunt had been checked at any other time. During an interview with the Director of Nursing on 8/17/11 at 12:10 p.m., she indicated she was not able to provide any information on Resident #133's shunt site being checked on the days she did not		been updated to feflect the care provided to each resident. Education has been provided to the licensed nursing staff to follow the plan of care. 2. A copy of the daily orders pertaining to diet will be passed along to the dietary manager, or designee, as well as getting a copy of the Nutrition/ Nursing Communication form. The Unit Manager or designee, will follow up in the daily clinical meeting to ensure the dietary manager has the updated changes. How the corrective actions will be monitored to ensure the deficient practice does not recur.1. The Performance Improvement Committee will follow for 3 months to establish substiantial compliance is maintained. 2. The Performance Improvement committee will follow for 3 months to establish substiantial compliance is maintained. This plan of ccorrection is this center's credible allegation of compliance.Preparation and or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed soley because it is required by the provisions of the federal and state law.	

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	receive dialysis. She indicated at this time the facility was creating forms for the nurses to start assessing shunts daily and every shift, according to the resident's care plan. During an interview with the Assistant Director of Nursing on 8/17/11 at 11:30 a.m., she indicated the facility did not have a policy on care of a resident receiving dialysis. 2. Physician's order dated 7/7/11 indicated Resident #74 was to receive a "regular diet, LCS (low concentrated sweets) with fruit secondary to greater energy needs with skin healing." Resident #74 is a quadriplegic with a diagnosis of diabetes and 11 open wounds. Care plan for Resident #74 related to impaired skin/tissue integrity, indicated that approach to goal of intact skin is to provide a diet as ordered and monitor nutritional status and dietary needs. On 8/16/11 at 12:40 P.M., Resident #74 was observed eating lunch in his room. The menu ticket on his tray indicated his type of diet as No Added Salt (4 Gm Na) Regular, instead of the current diet order dated 7/7/11. During an interview with the Dietary Manager on 8/19/11 at 12:00 p.m., who reviewed her records for Resident #74,			

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	she indicated current diet orders were dated 3/28/11, as a Regular Diet with No Added Salt (4 Gm Na), the diet he was currently receiving, and that nursing staff had not informed her of the 7/7/11 physician order for a change in diet. 3.1-35(g)(2)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure chemicals and sharps were stored securely to prevent access by residents who were confused and mobile. The deficient practice affected 13 of 22 residents on the secured dementia unit. (Residents #137, #138, #140, #141, #142, #147, #148, #150, #151, #153, #155, #156 and #157) Findings include: 1. On 8/19/11 at 9:05 a.m., the Quality Assurance Nurse indicated there were 13 residents on the secured dementia unit Reflections 2 who were able to ambulate or propel themselves in a wheelchair around the unit: Residents #137, #138,	F0323	It is the intention of Kindred Transitional Care and Rehabilitation Center-Greenwood to ensure our residents environment remains as free of accident hazzardsas is possible and that each resident revieves aqequate supervisionand assistive devices to prevent accidents. What corrective actions will be taken for those residents found to be affected by the decicient practice. The identified hazzards for residents #137, 138, 140, 141, 142, 147, 148, 150, 151, 153, 155, 156, and 157, were immediately removed from the unit. On 08/19/2011, the surveyor verified no chemicals were in the affected area and all locks were removed from the doors. How other residents having the same	09/15/2011

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	#140, #141, #142, #147, #148, #150, #151, #153, #155, #156 and #157. During an environmental tour on 8/18/11 at 9:40 a.m., with the Maintenance Manager, the Environmental Service Manager and the Executive Director, the following was observed on the secured dementia unit (Reflections 2): a. The sliding doors on the closet in Room 327 were not locked. The closet contained a tub of personal care items including bottles of hand sanitizer, mouthwash and shampoo. b. The sliding doors on the closet in Room 330 were not locked. The closet contained a tub of personal care items including shampoo, mouthwash and hand sanitizer. c. The sliding doors on the closet in Room 335 were not locked. The closet contained a tub of personal care items including shampoo and mouthwash. d. The sliding doors on the closet in Room 336 were not locked. The closet contained a tub of personal care items including shampoo, conditioner, hair spray and mouthwash. During an interview with the Executive		deficient practicewill be identified and what corrective action will be taken.Residents residing on this dementia unit had the potential to be affected by this practice and are no longer at risk. All chemicals are stored off of the unit. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice doed not recur.No chemicals are to be stored on the Reflections 2 unit. The chemicals are to be stored off of the unit. How the corrective actions will be monitored to ensure the deficient practice does not recur.Facility rounds will be completed to ensure compliance. The performance improvement committee will monitor the progress of the rounds to eslablish compliance. This will be monitored for a period of three months. This plan of ccorrection is this center's credible allegation of compliance.Preparation and or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed soley because it is required by the provisions of the federal and state law.	

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	Director on 8/18/11 at 11:00 a.m., he indicated the closet doors should be locked because there were items in the closets which could be hazardous to the residents if ingested. During an interview with the Executive Director on 8/18/11 at 3:00 p.m., he indicated they had decided to remove all the locks on the closet doors and all personal care, potentially hazardous items from the closets. 3.1-45(a)(1)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure safe food handling. Food temperatures were not maintained at the safe serving level. This had the potential to affect 149 of 159 residents who receive their meals from the facility. The facility also failed to ensure bread was not touched by staff while buttering for 4 of 18 residents served bread in the Reflections 2 dining room. (Residents #150, #151, #147, and	F0371	It is the intention of Kindred Transitional Care and REhabilitation- Greenwood to store, prepare and distribute food with sanitary conditions. What corrective actions will be taken for those residents found to be affected by the decicient practice. 1. The dietary manager instructed the staff to cover the pork chop and disguard the cottage cheese. 2. No correction was made for this resident. How other residents having the same	09/15/2011

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	#144) Findings include: 1. During observation of the lunch meal on 8/15/11 at 11:40 a.m., Cook #1 indicated she had already taken temperatures of the foods on the steam table and that they had just started to serve room trays. The facility Dietary Manager (DM) then took temperatures and the temperatures not maintained at a safe level were: Pork Chops, 118 degrees Fahrenheit (F) Cottage Cheese, different single serving bowls were tested and temperatures were 58 and 59 degrees (F). The DM instructed staff to cover the pork chops with foil so they would heat to proper temperature and discard the cottage cheese. During an observation of the lunch meal on 8/18/11 at 11:40 a.m., the facility DM took temperatures of the cold foods that were ready to be served. Temperatures that were not maintained at a safe level were: Coleslaw, different single serving bowls tested, temperatures recorded were 50, 51 and 55 degrees (F). The DM instructed staff to discard the coleslaw.		deficient practice will be identified and what corrective action will be taken.1. The dietary sataff members have been re instructed on maintaining food temperatures at the point of service.2. Staff have been inserviced on not handeling bread with clean bare hands. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice doed not recur.1. The dietary manager, or designee, will conduct food temps at point of service every meal. The temperaturtes will be recorded and reviewed. If there is a food temperature issue, the dietary staff have been instructed to contact the dietary manager and Executive Director, or designee. 2. Meal service will be observed periodically by the Registered dietitian, or designee, to ensure safe handeling of the foods. How the corrective actions will be monitored to ensure the deficient practice does not recur.1. The results of the temps will be submitted to the Performance improvement committee and monitored for a period of 3 months to establish substiantial compliance.2. The results of the observations will be submitted to the Performance improvement committee and monitored for a period of 3 months to establish substiantial compliance.This plan of correction is this center's credible allegation of	

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	During an interview on 8/18/11 at 11:50 a.m. with the DM, she indicated temperatures can be higher at the point of service. A review of the facility policy dated 10/31/2006, titled "Internal Food Temperature Matrix," on 8/18/11 at 12:10 p.m., indicated minimum holding temperatures on the tray line for potentially hazardous foods is 41 degrees or less for cold foods and 140 degrees or greater for hot foods. 2. Dinner on the Reflections 2 Hall was observed on 8/17/2011 at 4:57 p.m. CNA #2 was observed buttering bread for Resident #151 while touching the bread with bare hands. CNA #3 was observed buttering bread for Resident #150 while touching the bread with bare hands. RN #2 was observed buttering bread for Resident #147 while touching the bread with bare hands. LPN #1 was observed buttering bread for Resident #144 while touching the bread with bare hands. The Dining Standards Policy provided by the DON on 8/18/2011 at 3:35 p.m., and reviewed on 8/19/2011 at 11:00 a.m., indicated staff are to use utensils, deli tissue, dispensing equipment, or single use gloves to avoid bare hand contact of ready to eat foods.		compliance.Preparation and or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed soley because it is required by the provisions of the federal and state law.	

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	3.1-21(i)(2) 3.1-21(i)(3)			